

## **CHAPTER 5 ASSESSMENT PROTOCOLS**

### **5.1 Resources, Priorities, Concerns, (Family Service Plan)**

The information contained in the Family Service Plan must be gathered in collaboration with the family and only the information the families wishes to share should be documented on this page. The Family Service Plan is designed to provide the family with a mechanism to identify their resources, priorities, and concerns. Information gathered assists both the home visitor and the family in identifying strengths, needs, resources, and provides the opportunity to establish goals and record accomplishments.

#### **5.1.1 Guiding Principles for the FSP Process**

- Infants and toddlers are uniquely dependent on their families for their survival and nurturing. This dependence necessitates a family-centered approach to early intervention.
- Each family has its own structure, values, roles, beliefs and coping styles. Respect and acceptance of this diversity is essential to family-centered early intervention.
- Early intervention systems and strategies must reflect a respect for racial, ethnic and cultural diversity of families.
- Respect for family, autonomy, independence and decision making means that families must be able to choose the level and nature of early intervention involvement.
- Family/professional collaboration and partnership is the key to family-centered early intervention and successful implementation of the FSP process.
- No one agency or discipline can meet the diverse and complex needs of infants and toddlers with special needs and their families. Therefore, a team approach to planning and implementing the FSP is preferable, and strongly encouraged.

- A family need or concern is only a need if the family perceives it to be relevant.
- Any information the family does not want to be on the FSP must not be included and must remain confidential.
- The FSP is a “working” document. The process must lead to outcomes that assist the family in achieving their goals for themselves and their child.

### 5.1.2 Key Activities of the FSP

The abbreviated FSP is required for each child enrolled in the Community Nursing Component of the NICP. The form used is not as important as the data collected, examples of approved format are included at the end of this chapter. Note: “Family Service Plan Members” form by itself is no longer acceptable as the FSP.

The FSP is usually initiated on the first visit with the family and includes assessment planning. This is not duplicating data collected elsewhere, only data important to the family and outcome goals identified.

Infant/child, maternal and family strengths and needs are identified, i.e., “What is the family most proud of with their child and what are they the most concerned about?” “How does mother view her own health in relationship to possible subsequent pregnancies?”

Outcomes to meet infant/child, maternal and family needs are identified - this is the area to put potential or actual dates.

Review FSP at each visit and update as needed. Anytime a concern is documented on the FSP, a corresponding outcome goal must be documented as it is met.

**The family receives a copy of the FSP.** The home visitor and family can decide together when that happens. They may want to wait until the form is completed and at least some outcome goals have been met or they may want a copy each visit. If the family does not want a copy after each visit, a line can be drawn and then initialed by the home visitor. The home visitor, and parent shall sign and date the FSP when a page is completed or when copies are given to the family.

## **5.2 Infant Screening Tools**

The Ages and Stages Questionnaire or Denver II may be selected at the discretion of the contractor to assess the child's performance on various age-appropriate tasks. These tools are valuable in screening children for possible problems, confirming suspicions with an objective measure, and in monitoring children at risk for developmental problems, such as those who have experienced perinatal difficulties. It is designed to compare a given child's performance on a variety of tasks to performance of other children the same age.

### **5.2.1 Ages and Stages Questionnaire**

The Ages and States Questionnaires (ASQ): A Parent-Completed, Child Monitoring System includes a series of questionnaires designed to identify infants and young children who show potential developmental problems. Each questionnaire features 30 developmental items that are written in simple, straightforward language. The items are divided into five areas: communication, gross motor, fine motor, problem solving, and personal-social. An overall section addresses general parental concerns. Children are identified as needing further testing and possible referral to early intervention services when their ASQ scores fall below designed cutoff points.

The ASQ materials consist of reproducible master questionnaires, age-appropriate scoring and data summary sheets, and the User's Guide which also contains activity sheets for parents that correspond to the ASQ age intervals. A Spanish translation master set of questionnaires is also available.

### **5.2.2 Denver II**

The Denver II consists of 125 tasks, or items that are arranged in sections on the test form:

- Personal-Social
- Fine Motor-Adaptive
- Language
- Gross Motor

Also included are five "Test Behavior" items that rate the child's behavior during testing. The Denver II is best completed between 4 and 6 months for the first

time and may be used at any time the family or nurse would determine a need during the first year of age.

The values for using the Denver II are:

- To provide an organized, clinical impression of a child's overall development and to alert the user to potential developmental difficulties
- To use as a tool for teaching the family normal growth and developmental parameters and allowing them to be part of the teaching process with their child

The address for ordering forms, manuals and kits:

**Denver Developmental Materials**  
**P.O. Box 371075**  
**Denver, Colorado 80237-5075**  
**(303) 986-9302**

### **5.2.3 Risk Identification Tool**

The *Resiliency and Risk Identification System for Children* (RRISC 8) was developed by Karen Van Wie through a Flinn Grant . CHN contractors may utilize the RRISC8 or another risk identification tool as a measurement of cumulative risk frequency and intensity of services. The CHN may conduct a risk assessment at the first home visit, and as family situations warrant.

## **5.3 Neonatal and Pediatric Assessment**

All "regular" home visits by the Community Health Nurse should include an assessment of the infant/child's physical, developmental, environmental, and family relationship status. The assessment form should be used to describe any *Concerns* of the parent or home visitor, to describe the home visitor's *Impressions*, and to document the *Plan* for follow up. The level of risk should also be recorded here.

## **5.4 Maternal Screening Tools**

### **Postpartum Mood Disorder\***

Postpartum Mood Disorders affect millions of women worldwide, regardless of race, age, culture, or socioeconomic status. Symptoms of Postpartum Mood Disorders vary and may include feelings of sadness, anger, frustration and confusion.

A mother experiencing a Postpartum Mood Disorder may feel alone and ashamed of her symptoms. Fathers are also impacted by Postpartum Mood Disorders and have their own experience that may be very different from the mother. These differences place an enormous amount of stress on the couple's relationship and it can prove a difficult time for the entire family.

The <http://www.postpartumcouples.com> website was created to provide information and resources to mothers and fathers on Postpartum Mood Disorders. The resources there are intended to provide couples, families, and professionals with information and tools to help mothers and families heal from Postpartum Mood Disorders.

\* information taken from <http://www.postpartumcouples.com>

### **5.4.2 Edinburgh Postnatal Depression Scale (EPDS)\*\***

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6 –8 week postpartum examination. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than 5 minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (\*) are reverse scored (i.e., 3, 2, 1, and 0). The total score is determined by adding together the scores for each of the 10 items. Validation studies have utilized various threshold scores in determining which women were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 9 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be immediately referred for follow-up. Even if a woman scores less than 9, if the clinician feels the client is suffering from depression, an appropriate referral should

be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel. Users may reproduce the scale without permission providing the copyright is respected by quoting the names of the authors, title and the source of the paper in all reproduced copies.

\*\* information taken from

<http://health.utah.gov/rhp/pdf/EPDS.pdf#search='edinburgh%20postnatal%20depression%20scale'>

The Edinburgh Postnatal Depression Scale is to be completed at each first home visit of NICP enrolled children (foster/adoptive excluded). Results are to be recorded on page two of the nursing visit form. Any score equal to or higher than 10 must be referred for follow up care. This will vary in each community, but could include PPD support groups and a referral to the primary care physician and/or any other appropriate referral. The referrals must be written in on the visit form also.

#### **5.4.3 Maternal Wellness Assessment/ Preconception Care**

“Preconception care is defined as a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman’s health or pregnancy outcome through prevention and management.” Recommendations to Improve Preconception Health and Health Care-United states, A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. MMWR 2006; 55 (No.RR-6):3-4.

The Community Health Nurse, by virtue of following NICP enrolled infants, is in the unique position of being in the home and working with the mother of a premature infant or infant with a less than optimal birth outcome. The mother who has had a preterm infant is at a statistically higher risk of having another preterm infant. The goal of this aspect of the CHN follow up visit is reduction of risk factors that can lead to preterm delivery in a subsequent pregnancy.

To this end, the CHN will use appropriate screening tools to screen and then provide education to the mother of the infant about: reproductive awareness; environmental toxins and teratogens; nutrition and folic acid; genetics; substance use including tobacco and alcohol; medical conditions and medications; infectious diseases and vaccination; and psychosocial conditions and the help to link her to community services when appropriate.